ADMINISTRATION AND POLICY IN MENTAL HEALTH: TWENTY YEARS AFTER

Boris M. Astrachan, M.D.

We have been buffeted by the winds of extraordinary change over the past 20 years. Like the heroes of the Dumas novel, The Three Musketeers, in the sequel 20 years later we are confused by our inability to achieve our youthful ideals, perplexed by the ongoing struggle, and in perhaps a somewhat more mature way, still confident that things will turn out well. The past 20 years have witnessed extraordinary changes in the science bases of practice; a dawning acceptance of the important of organizations in health care and the inadequacy of the private office as the primary setting for delivery of care; a substantial growth of the independent practice of psychology and social work and dramatic change in professional roles. However, I believe that the single most important driving force for change has been in the nature of the growth of funding in health care; and the consequent corporatization and privatization of health care.

All health care expenditures have been growing at rates exceeding the growth in our gross national product for over 30 years. Government entitlements fueled enormous growth in service availability and delivery. And increasingly, the inflation in costs has acted to constrain other human services.

In order to obtain the agreement of organized medicine for Medicare and Medicaid, the federal government agreed that services would be paid for through a “fee-for-service” mechanism. Charges were to be linked to costs, and

In 1972, Dr. Astrachan was the director of the Connecticut Mental Health Center and Professor of Psychiatry at Yale University School of Medicine where he remained for the next 17 years. During those years, he was a member of the ADAMHA Advisory Board and member and then chair of the National Institute of Mental Health Study Section on Mental Health Services Research. For the past three years, he has been a member of the IBM Mental Health Advisory Board. In 1990, Dr. Astrachan became Professor and Head of Psychiatry at the University of Illinois at Chicago.
if costs rose because of higher salaries for staff, or overhead or the cost of new technology, then so too might charges. And insurers went along with higher costs and charges. And inflation flourished.

Medicaid costs rose, as did Medicare, but Medicaid had to be paid out of state dollars matching federal dollars, and states had to agree to pay their share of costs. For example, let me construct the mythic state of Illinecticut. It had a $1 billion budget in 1992. The Medicaid costs were $500,000 million, of which the state paid half, $250,000 million. Thus the state had a $750,000 million budget for education, welfare, its mental health system, etc.

Our State of Illinecticut was in a recession in 1992 and has no dollars to meet inflationary costs in 1993. However, it must meet its share of Medicaid. Costs were 10% over budget in 1992. Cuts in 1992 will have been necessary, or may have carried forward into 1993. Additional cuts must be made in 1993. You can see how the State's fixed budget expenses will be constrained, how other departmental budgets will be cut, and how, at least some will advocate for increased taxes.

Exactly the same issues pertain in the private sector. More is spent on health costs in building a car than is spent on the cost of the metal in the car. Health care costs are an important reason for the high cost of goods produced in the U.S. What exactly does all this mean? It means that over the past decade and into the next century the major emphasis in health care has been and will be to restrain expenditures. New dollars for services will be limited. New dollars for new programs in the community will continue to be limited if health care costs are not contained. Thus, services that already exist will be under stress, and the opportunity to develop new services will be constrained.

The pressures have led to dramatic changes in mental health care delivery. Two decades ago, we were witness to an extraordinary expansion of services, and even the illusion that we might achieve equitable access to care. Mental health administrators worked in an environment of plenty, and although one never felt that resources were sufficient, there was enough to experiment, to innovate, to test new models of care, to serve new populations. But as costs continued to rise in an unchecked manner, we began to witness myriad attempts to restrain expenditures.

Services have become more organized and, on balance, that is good. More people are served, access for some has improved, and there is an increased emphasis on monitoring care in a formal review process. But, in the process, some excellent individual services have been underfunded, and important professional autonomy has been constrained—and that is not in the interest of patients.

There has been increasing pressure placed upon state services because of the force of recession and the inflationary growth of Medicaid. Just a few years ago state programs were growing. Now they are shrinking. In a few states innovative ways of merging dollars from mental health agencies and Medicaid are